STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE
300 Capitol Mall, Suite 1700
Sacramento, California 95814

INITIAL STATEMENT OF REASONS

Date: June 5, 2009 **REG-2007-00054**

STANDARDS FOR HEALTH HISTORY QUESTIONNAIRES IN HEALTH INSURANCE APPLICATIONS, PRE-ISSUANCE MEDICAL UNDERWRITING AND RESCISSION OF HEALTH INSURANCE POLICIES

INTRODUCTION

The Insurance Commissioner is the independently elected official responsible for regulating the business of insurance, which includes health insurers who conduct pre-issuance medical underwriting of individual health insurance applications, issue health insurance policies and in some cases rescind, limit or cancel those policies under specified circumstances and limits imposed by the Insurance Code's prohibition of postclaims underwriting. The Commissioner has broad authority to conduct market conduct examinations and receives thousands of consumer complaints each year. The Department of Insurance investigates each complaint received and keeps tabs on trends in the insurance industry through both consumer complaints and market conduct examinations.

Over the past three years, consumers have made the Commissioner aware of their increasing concerns about postclaims underwriting and rescission. Rescission refers to the retroactive cancellation of an insurance contract back to the effective date of coverage, thereby extinguishing the health insurance coverage that was formerly in place. As a result of the revocation of their insurance coverage, many of these consumers were left with responsibility for substantial unpaid medical bills. At the same time, the Commissioner discovered that as a general practice, insurers had placed too much reliance on the responses provided by the applicant on the health history questionnaire submitted as part of the health insurance application and had not performed sufficient pre-issuance underwriting of the application using external, objective sources of health information.

Consumers also complained of overbroad, misleading and confusing questions on the health history questionnaires: the proposed regulations are intended to address this problem. The Commissioner learned that consumers were confused by the complicated, technical questions on such questionnaires and intended to answer truthfully but found it difficult to complete the questionnaire accurately. After medical claims were submitted or care was sought by the insured under their insurance policy, the insurers would revisit the application and commence additional underwriting to determine whether to rescind the insured's coverage. These rescission investigations resulted in several thousand rescissions of individual Californians who bought individual health insurance policies over the past four years, often leaving health care providers unreimbursed for care they rendered in good faith when the insured had coverage and leaving

consumers without the means to pay for past medical claims and, often, without future health coverage.

Since 2006 the Commissioner has conducted several in depth market conduct examinations of health insurers' pre-issuance medical underwriting practices, rescission practices and related claims handling practices. He found that insurers' practices not only differed substantially across the business but, more importantly, that insurers did not appear to have a clear and consistent understanding of what the Insurance Code required to achieve compliance with the law governing pre-issuance medical underwriting, prohibited postclaims underwriting, crafting of clear and unambiguous health history questions, conduct of rescission investigations and claims handling related to such investigations. Due to the extreme hardship experienced by insurance consumers whose coverage is illegally rescinded and the difficulty such consumers have in obtaining replacement individual health insurance, the Commissioner has determined that insurance consumers need greater protection from unlawful rescissions and, accordingly, proposes these regulations.

The health insurance industry will benefit from the establishment of standards for pre-issuance underwriting and the other standards set forth in the proposed regulations. The proposed regulations are one of the methods deployed by the Commissioner in an effort to clarify and create greater specificity regarding the general prohibition of postclaims underwriting. There has been widespread confusion and disagreement in California among regulators, consumers and insurers about the details of prohibited postclaims underwriting; a practice that California courts have been struggling with even before *Hailey v. California Physicians' Service*, Cal. App. 4th Dist. Jan. 22, 2008 was decided. Later in 2008, *Ticconi v. Blue Shield of California Life & Health Ins. Co.,* 160 Cal. App. 4th 528 (Cal. App. 2d Dist. 2008*)* was decided. In *Ticconi*, in order to make a judgment on the class certification issue, the Court interpreted Insurance Code section 10381.5, which requires an application to be attached to or endorsed on an application before the insurer can rely on statements made by an insured in the application to rescind the insured's coverage. The *Ticconi* court rejected insurer arguments that this Insurance Code statute was satisfied by a delayed mailing of a copy of the individual's health insurance application, separated from the issuance and delivery of the policy and insurer's attempts to characterize this delayed delivery as an "endorsement." Instead, the Court held that the copy of the individual's application must be attached to the policy at the time of the delivery, not later. The proposed regulations are consistent with California case law interpreting Insurance Code section 10381.5.

SPECIFIC PURPOSE AND REASONABLE NECESSITY OF REGULATION

The specific purpose of each adoption and the rationale for the Commissioner's determination that each adoption is reasonably necessary to carry out the purpose for which it is proposed are set forth below.

SECTION 2274.70: PURPOSE

This section opens with the general purpose of the proposed article: to clarify and make specific the application of statutes governing the insurance policy as an entire contract, the attestation required by agents assisting applicants in the submission of health insurance applications, the making of and insurer's use of false statements made in such applications, the attachment of the individual's application for health insurance to the policy when issued and delivered and the prohibition of postclaims underwriting.

Three of the stated purposes of the proposed regulations pertain to the nature of questions included on a health history questionnaire which is part of both the individual health insurance application and the health insurance policy itself. Specifically, the Commissioner finds that it is reasonably necessary to establish the requirements for health history questions in order to facilitate determinations by the Commissioner that questions requested by an insurer for inclusion in the health history questionnaire are clear and unambiguous. While the Insurance Code allows for variation among insurers in the types and phrasing of health history questions included in their respective health history questionnaires, the proposed regulations define the characteristics of questions that will not be approved by the Commissioner because they are unintelligible, uncertain, ambiguous, abstruse or likely to mislead an applicant pursuant to Insurance Code section 10291.5(b)(1). Another purpose of the proposed regulations is to limit the health history questions to those that are reasonably necessary to the insurer for completion of the insurer's medical underwriting.

The Commissioner has discovered considerable confusion and disagreement within the insurer community concerning exactly what conduct constitutes pre-issuance medical underwriting that would permit an insurer to legally rescind insurance coverage. The Commissioner finds it necessary to set forth requirements for the completion of pre-issuance medical underwriting to reduce such confusion for both insurers and consumers who pay monthly premium and rely on this health insurance coverage.

On January 1, 2009, the legislature enacted a new law requiring agents who assist applicants in the submission of individual health insurance applications to attest to such assistance. The health insurance industry has embraced the use of the Internet in the submission of such applications which greatly simplifies the process of submitting applications but complicates the actual implementation of the attestation requirement where a traditional "written" application is not submitted. The Commissioner finds that it is necessary to provide additional guidance to both agents and the insurers who rely on the agent's attestations, especially with regard to the electronic submission of individual health insurance applications.

In order to combat fraud in the individual health insurance industry, insurers have been actively investigating potential situations where an applicant might have misrepresented material information on a health history application causing an insurer to accept a risk that the insurer

would have otherwise rejected. Such rescission investigations are currently conducted without benefit of any requirements regarding notice to the insured or the insured's providers or timeframe for completing the investigation or the handling of claims during the investigation period. The Commissioner found wide variation in how insurers conducted such investigations and determined that fairness to consumers and providers who rely on the insured's health insurance coverage necessitated the establishment of standards for conducting such investigations.

SECTION 2674.71: SCOPE

This section limits the applicability of the proposed regulations to health insurance policies, insurers and agents as defined in Insurance Code section 106(b). These proposed regulations do not extend to group health insurance policies that are not medically underwritten such as guaranteed issue small group policies. However, some group policies are medically underwritten and are therefore subject to the proposed regulations.

The proposed regulations do not purport to establish limits on the approaches or methodologies that could be deployed by insurers in their pursuit of improved medical underwriting within the constraints of existing law. In fact, new data sources and new underwriting information and techniques are expected to be developed in the future. To the extent these unknown methods would be useful to insurers seeking to efficiently complete medical underwriting within the parameters of the Insurance Code, it is not foreseeable that the proposed regulations will constrain the use of these additional underwriting techniques.

SECTION 2674.72: DEFINITIONS

This section defines technical terms used in the proposed regulations. In this section, key terms are defined that are used throughout the proposed regulations often in different contexts. Some of these terms are terms of art in this industry and may have one meaning to consumers and a different meaning to insurers. This section is therefore reasonably necessary in order to carry out the purpose of the proposed regulations and to help clarify the standards and their application to affected parties who are health insurers and health agents.

Section 2674.72(a) Policy

We look to Insurance Code section 380 for guidance and adapt the general definition of policy as the written instrument of the insurance contract applied to health insurance coverage that is the subject matter of these proposed regulations.

Section 2674.72(b) Reasonable Layperson Standard

The prudent layperson standard is used to determine if an emergency room visit must be reimbursed by Medicaid or Medicare, federal health programs. This standard has been adapted by private payors and is widely used in making reimbursement or coverage decisions regarding emergency room visits. In this context, a reasonable layperson who possesses an average knowledge of health or medicine standard is applied when determining if the emergency room visit was warranted. In the proposed regulations the standard has been modified for use in the context of an insurer whose medical underwriters evaluate a layperson's responses to technical, clinical questions on a health history questionnaire. While insurers know that the applicants are usually lay persons who possess an average knowledge of health or medicine, it is important to reinforce this fact in this context, especially during post-issuance rescission investigations when the insurer's underwriters are comparing doctors' written findings in medical records to a layperson's responses on a health history questionnaire.

Section 2274.72(c) Questions

A common everyday term, "questions," takes on a broader meaning in the context of the all-important health history questionnaire. We chose to include within this definition, statements made in the health history questionnaire as well as disclosures required by the insurer in this definition. The importance of this definition becomes more evident in the proposed regulations that follow which address the nature and character of the questions that are allowed to be approved by the Commissioner on health history questionnaires that are part of the insurance policy.

Section 2274.72(d) Personal Health Record

A new, innovative and evolving tool used by some insurers to retain personal health history information for the consumer's use. Its use is not yet widespread, but it is greatly expected to aid consumers in the following types of situations: where a consumer is expected to recall minute detail about their previous health history experiences. The kind of detailed health history information contained in a Personal Health Record includes exactly the kind of information sought by an insurer on an individual health insurance application. Since information in a Personal Health Record is objectively established, it represents a more comprehensive, more accurate and reliable source of information that the insurer could use to medically underwrite an application for individual health insurance. Use of these records could help applicants avoid problems remembering every test, prescription, order, diagnosis, procedure or treatment they may have had in the past five to ten years that they are asked to recall and record on a health history questionnaire.

Section 2274.72(e) Material

"Material" is a common term of art used in the insurance industry, typically in conjunction with a misrepresentation. Since the proposed regulations address how health history information is gathered and used by insurers as they underwrite a health insurance application, it is important to define material as the factor(s) that determine whether an insurer will assume or decline the prospective risk posed by an individual's application. Existing law limits the definition of a false statement in an application to a material fact which in the specific context of the proposed regulations means that a material misrepresentation must be tied to a specific medical underwriting guideline relied on by the insurer.

Section 2274.72(f) Medical Underwriting

The core of these proposed regulations is the delineation of what conduct constitutes "completion of medical underwriting," one of the two required tasks in the postclaims underwriting statutes that must be accomplished before an insurer can assert a legal rescission, cancellation or limitation of a health insurance policy. Medical underwriting is a process that includes several components and steps and that includes evaluation of differing types of health history information applied to an insurer's medical underwriting guidelines which are often complex, dynamic and voluminous. This definition includes not only the process of examining different types of relevant health history information but also the insurer's determination of whether to accept the proposed insurance risk presented by the applicant's request for health insurance coverage.

Section 2274.73: STANDARDS FOR HEALTH HISTORY QUESTIONS ON AN APPLICATION FOR HEALTH INSURANCE COVERAGE

The individual applicant's responses to questions, as defined, on the health insurance application will likely remain the single most important source of information relied upon by the insurer to complete medical underwriting. Further, the Insurance Code's prohibition of postclaims underwriting requires insurers "to resolve all reasonable questions arising from written information submitted on or with the application". In short, the questions on the application are crucial to the insurer's job of completing pre-issuance medical underwriting. The proposed regulations include considerable detail regarding the characteristics of questions that are allowed as well as those that will not be approved for use, in a health history questionnaire.

In this section, the proposed regulations contain the overarching instruction that a reasonable layperson standard must be used by insurers to evaluate the applicant's responses. While this may seem to be stating the obvious, the Commissioner found that underwriters poring over applications during rescission investigations often assumed that the applicant had the same level of understanding of a condition, diagnosis or treatment as was reflected in doctors' notes contained in medical records. A doctor's statement of a diagnosis or medical treatment recorded in written medical records is often not the same as a layperson's understanding reflected in an answer on a health history questionnaire.

In this section, the scope of questions allowed to be asked on the health history questionnaire is limited to those absolutely necessary for the insurer's application of its underwriting guidelines. This is necessary to avoid demanding that the applicant provide more information than necessary, in recognition that health history questionnaires used today are long, thorough and wide-ranging. The basis for judging what medical information may be requested is limited to what is essential to the insurer in calculating the risk posed to the insurer by the applicant's request for coverage. The proposed regulation does not constrain insurers who are entitled to obtain the medical information they need in order to make a determination according to their medical underwriting guidelines.

The section lists characteristics that questions on a health history questionnaire should strive to reflect, and provides specific guidance regarding the characteristics of questions that will not be approved. Prescriptive standards for questions that will be approved are established in this section. While the descriptions of questions to be avoided, such as those that are compound or unlimited in time and scope (e.g. have you ever had acne or psoriasis?) might seem self-evident, the Commissioner finds such guidance necessary to assist insurers with the difficult task of constructing health history questionnaires that can be approved by the Commissioner. This section sets forth the characteristics of questions, such as being clear, specific, unambiguous and written in easy-to-understand language that can be approved by the Commissioner. The time period that a question may cover must be limited to match the insurer's underwriting guidelines.

In order for insurers to get the most accurate and complete, the proposed regulations encourages questions that seek more concrete objectively verifiable information such as diagnoses, treatments or office visits rather than symptoms. Because an individual's perception of symptoms is largely subjective and can vary substantially from person to person, questions that ask about an applicant's symptoms or reaction to symptoms are not a good source of health history information for underwriting purposes. Symptoms can be fleeting, highly subjectively perceived and not necessarily indicative of illness. Questions which require the applicant to evaluate the severity, meaning or the significance of symptoms do not produce accurate, complete and independently verifiable health history information for medical underwriting purposes. Accordingly, the proposed regulations discourage such questions.

In order to facilitate the completion of medical underwriting by the insurers, questions must allow for more than a simple yes-or-no response; it is reasonably necessary that the regulations specify that the responder must be allowed to indicate that he or she is not sure or doesn't know the answer. The Commissioner finds these additional response options necessary to avoid forcing the consumer who can't recall or doesn't know into an incorrect yes-or-no response. "Not sure "or "Don't know" responses may be honestly provided and present the insurer with an opportunity to contact the applicant for further clarification. Further, if an applicant cannot recall the answer to a health history question, the applicant must be allowed to indicate this on the questionnaire. Insurers can follow up with telephone interviews or request medical records to

obtain independent information if the applicant can't recall information that is necessary for the insurer's application of the medical underwriting guidelines.

Existing law prohibits any question which asks the applicant if the applicant has been tested for HIV and this section specifies the range of questions on this subject which are prohibited.

In this section, insurers are required to either use separate health history questionnaires for each individual applicant or solicit separate responses for each individual. Oftentimes, one spouse would complete the health history questionnaire for both spouses. A single health history question posed on an application intended to cover five individuals in a family caused considerable confusion regarding to whom a yes-or-no response actually applied. For this reason, the proposed regulations require an application intended to cover more than one person, such as a couple or family, is required to offer separately health history questions for each individual. This format will have the effect of reducing confusion for the consumer and as well as the underwriter who relies on each individual's response to each health history question to complete medical underwriting for each applicant.

Lastly, the Commissioner finds it necessary to expressly prohibit an applicant from responding to a question whether or not an agent assisted in the submission of the application. The reason for this constraint is found in the definition of what conduct constitutes "assisting an applicant in submission of the application" in Section 2274.76. A broad and expansive definition of assistance to an applicant in the submission of an application is proposed in order to protect consumers from receiving misinformation after the application has been submitted but prior to the issuance of the policy. Since applicants have an ongoing legal obligation to provide accurate and correct health history information to the insurer up to the time of issuance, any conversations, even a casual one, with an agent after the initial application is submitted that involves responses to the health history questions qualifies as assistance under the proposed regulations. Because an applicant might not view this type of communication as assistance, especially after the application has been initially submitted, this section prohibits asking the applicant to make a determination as to whether the agent has assisted.

SECTION 2274.74: STANDARDS FOR AVOIDING PROHIBITED POSTCLAIMS UNDERWRITING

The Commissioner finds it necessary to list the types of actions and steps that an insurer shall undertake in order to meet the Insurance Code's two pronged test to avoid prohibited postclaims underwriting: completing medical underwriting and resolving all reasonable questions arising from written information submitted on or with an application prior to issuing a policy.

In this section, each of these tasks is broken down into several different components. The proposed regulation allows, but does not require, use of a Personal Health Record by the insurer to support its completion of medical underwriting. Since Personal Health Records are not yet in

widespread use, we chose to make this an option but not a requirement. Commercially available claims databases, which may provide relevant historical medical utilization data about an applicant, can be accessed by health insurers in the marketplace and can provide invaluable information to an insurer as the insurer proceeds to complete medical underwriting. Similarly, every insurer can check its own internal claims database to detect any past medical utilization by an applicant. For example, an applicant for individual health insurance might have previously been covered by an employer's group policy with the same insurer. In this circumstance, the regulation requires the insurer to check its own internal claims database for past medical claims generated by the applicant. Claims data contains medical procedure codes, diagnoses and dates of past service as well as other information potentially useful in completion of medical underwriting.

The proposed regulations suggest, but do not require, that an insurer seek claims data from prior insurers in recognition of the fact that this data source may not be widely available even though this data would be tremendously helpful in the medical underwriting process. Commercially available pharmaceutical information, however, is widely available and serves as an excellent source of health history information to assist the insurer in completion of medical underwriting of an applicant. Accordingly, it is reasonably necessary to require that insurers access commercially available pharmaceutical data. The Commissioner believes that use of commercially available pharmaceutical databases is currently industry-standard practice in California.

The proposed regulations recognize that the wide array of medical information available from commercial sources and internal databases will require the insurer to evaluate the information gained from each of these sources for accuracy, completeness and consistency. Further, the health history information gleaned from the external data sources must be cross-checked for accuracy and consistency with the self-reported information from the applicant. The proposed regulations require that identified inconsistencies be resolved by the insurer as part of the completion of medical underwriting.

We chose to set a "reasonableness" standard for the availability of health history information in recognition of the variability of the data sources and that in some cases the external data sources may yield very little in the way of health history information about an applicant. For example, in the case of a healthy young person, there may simply not be any prior claims or pharmaceutical data available and the insurer may need to rely solely on the application submitted by the individual.

We find it necessary to require insurers to check data received for accuracy, completeness and consistency of health history information obtained during the medical underwriting process. The proposed regulations require that the insurer evaluate self-reported health history information using a reasonable layperson standard unless the applicant appears to have had formal medical training.

One of the benefits of the newly enacted statutory requirement that an agent attest to the fact that the agent assisted an applicant is to allow insurers the opportunity to check with an assisting agent regarding any question the insurer might have about the individual's application. In some but not all cases, agents who assisted applicants might be of assistance to the insurer as the insurer proceeds to complete medical underwriting.

The second prong of the postclaims underwriting statute requires an insurer to resolve all reasonable questions arising from written information submitted on or with the application. The proposed regulations address this requirement by enumerating various approaches to resolving inconsistencies as a critically important part of the prospective risk assessment done by the insurer. The ultimate goal of completing medical underwriting and resolving all reasonable questions arising from written information submitted on or with the application is to assess the prospective risk posed by the applicant. This assessment must be grounded in sound actuarial principles reflected in the insurer's rating criteria and underwriting guidelines. Determination of the risk flows from the insurer's assessment of all of the health history information gathered during the medical underwriting process and from comparison of the body of health history information to the insurer's medical underwriting guidelines.

During the Commissioner's market conduct examinations, the Department discovered multiple instances where inconsistencies on applications, including information provided on the applications by agents who assisted applicants, were not resolved during the pre-issuance underwriting process. In these cases, the insurer later rescinded the health insurance coverage even though rescission could have been avoided had those inconsistencies been resolved prior to issuing the insurance policy. It is for these reasons that the proposed regulations include several requirements pertaining to an insurer's need to follow up on *any and all* information that appears inadequate, unclear, incomplete or doubtful, but this follow up is required only if the inconsistencies or doubts are relevant to the insurer's medical underwriting guidelines and the insurer's assessment of the prospective risk. The Commissioner adopts a "reasonable and appropriate" standard for insurer's follow up of inconsistencies in the health history information gathered during pre-issuance medical underwriting. This reasonableness standard extends to the proposed regulation directing an insurer to obtain clarification from an applicant, if necessary to resolve inconsistencies in the information gathered, and to the directive to obtain additional information, as necessary, to resolve every inconsistency identified on the individual's application or through subsequent communication with the applicant. The proposed regulations encourage insurers to engage in direct communication with the applicant subsequent to the submission of the individual's applicant in every situation where inconsistencies arise as the insurer strives to complete medical underwriting.

The ultimate goal of the proposed standards for avoiding postclaims underwriting is to describe the circumstances under which insurers may retain the right to rescind, limit or cancel an insurance policy after it has been issued if the insurer finds that an insured has made a material

misrepresentation that would have caused the insurer to decline to accept the proposed risk. The proposed regulations setting standards for completion of medical underwriting and resolving all reasonable questions arising from information submitted on or with an application and for verifying the accuracy and completeness of such information will allow the insurer to conduct a legal rescission if absolutely necessary.

The prohibition against conducting a rescission, cancellation or limitation after the insurer is on notice of a claim under the policy does not apply if the insurer can demonstrate that all of the standards proposed in this section have been met.

Section 2274.75: DOCUMENTATION REQUIREMENTS AND EXAMINATION BY COMMISSIONER

The standards for avoiding prohibited postclaims underwriting proposed in the preceding Section 2274.74 set the stage for the enumeration of the documentation requirements proposed in this Section 2274.75.

Every documentation requirement proposed in this section flows from one or more of the standards required of insurers in completing medical underwriting and resolve all reasonable questions arising from written information submitted on or with the individual's application for health insurance, or in the insurer's conduct of post-issuance rescission investigations. This includes documents and communications generated by an insurer during the underwriting process where the insurer engaged in a determination of the accuracy and completeness of the various pieces of information gathered by the insurer during medical underwriting.

The proposed regulations regarding documentation and document retention requirements related to the pre-issuance medical underwriting processes are entirely consistent with statutory requirements for other transactions in the business of insurance in general.

The proposed regulation specifies that certain communications such as those that might occur between an agent who assisted an applicant and an insurer must be documented and retained. In recognition of the vast and common use of electronic communications, the proposed regulation specifies that all electronic records are included in the proposed documentation and record retention requirements. In an era of electronic medical claims submission as well as secure email communication, this proposed regulation that defines communications subject to examination and retention to include electronic records is absolutely necessary.

The proposed regulation includes communications related to the processes addressed throughout new Article 11, which include all communications, electronic or otherwise, generated during a post-issuance rescission investigation. Since the post-issuance rescission investigation frequently involves medical claims or notice that a claim is about to be submitted through a medical management or service authorization request from a health care provider, electronic

claims, electronic versions of medical records as well as garden variety email communications are all necessary to the Commissioner's execution of his examination responsibilities.

Section 2274.76: AGENT ATTESTATION AND NOTIFICATION REQUIREMENTS WHEN HEALTH INSURANCE APPLICATIONS ARE SUBMITTED TO INSURERS

As of January 1, 2009, state insurance law requires agents who assist applicants in submitting an application for individual health insurance to state and confirm — or attest — as to their assistance. The proposed regulations are necessary to clarify exactly what conduct constitutes assistance, under what circumstances agent assistance has occurred and the timing of an agent's attestation if the assistance occurs after the submission of the application but prior to the issuance of a health insurance policy.

Existing law requires an applicant to continue to submit any health history information to an insurer who is considering an application even after the initial application is submitted. For example, if an applicant is physically injured or is diagnosed with a condition or disease after the application is submitted but prior the insurer's issuance of the policy, the applicant is obligated to provide this supplemental health history information to the insurer. Similarly, an agent who provides information or advice of any kind to an applicant either before or after the applicant submits an application for health insurance is required by the proposed regulation to attest to such assistance. This requirement is necessary for two reasons: (1) to inform the insurer in the event that the insurer seeks additional information from the agent as the insurer proceeds to complete medical underwriting and (2) to comply with the intent of the statute, which is to notify insurers of an agent's assistance.

The circumstances, timing and frequency of an agent's attestation as to assistance to an applicant who has submitted or intends to submit an application for health insurance is complicated by the widespread use of the Internet by both applicants and agents in the submission of health insurance applications. Often agents receive a written application from an applicant or receive information from an applicant by telephone and proceed to enter the applicant's data into an online application and submit the individual's application on their behalf using an electronic signature. This mode of application submission by an agent on behalf of an individual has created opportunities for fraud. The Commissioner has detected cases where agents have falsified information in the electronic submission by entering materially different (and untrue) information from what was provided to the agent by the applicant.

The proposed regulations make unambiguous the requirement that an agent attest to assisting an applicant during the entire time period during an insurer's consideration of the application: This includes the period starting with the submission of the application through the time of issuance of the policy. If an agent provides assistance, as defined, during any point during this time period, the agent must attest accordingly. This requirement protects the insurer in the event that the agent provides incorrect advice or information to the applicant. For example, an applicant

may have omitted a recent visit to a doctor on the application. The applicant may contact the agent and ask if this information should have been provided to the insurer. If the agent answers the applicant's question, the agent has assisted the applicant. If this communication is the first contact between the applicant and the agent in the case where an application is submitted electronically to the insurer through an agent's web site, the proposed regulations require the agent to notify the insurer, stating that assistance was provided. Similarly, if an applicant accesses an agent's web site and submits the application directly to the insurer through the agent's web site but has no communication with the agent, the proposed regulations require the agent to notify the insurer of this fact thus ensuring that the insurer will know whether or not assistance was provided at that time.

The proposed regulations require the agent to notify the insurer and attest to either situation: that assistance was provided or that assistance was not provided. Insurers are entitled to know whether or not assistance was provided by an agent in the event that the insurer chooses to contact the agent to discuss the application. The agent may have additional information about the applicant that might be relevant to the insurer's medical underwriting but may not be reflected on the application. Unless the agent has notified the insurer as to the fact of the agent's assistance to the application, the insurer will not know whether or not the agent could provide additional information regarding the applicant. The Department has approved several of these attestation forms submitted by insurers and the approved forms are entirely consistent with the proposed regulations.

Section 2274.77: RETURN OF THE COMPLETED APPLICATION FOR HEALTH INSURANCE COVERAGE AT TIME OF POLICY TRANSMISSION; NOTICE AND COMMUNICATION REQUIREMENTS

Current state insurance law requires an insurer to return a copy of the completed application for health insurance to the insured at the time the policy is delivered to the insured. The proposed regulations are necessary to clear up the confusion that has existed within the insurance industry with respect to the timing of the return of the completed application. Prior to the *Ticconi v. Blue Shield of California Life & Health Ins. Co*., 160 Cal.App.4th 528 (2008) decision, insurers were typically not returning a copy of the individual's application until after the policy was delivered. *Ticconi* interpreted the Insurance Code to mean that the individual's application must be returned *at the same time* as the delivery of the insurance policy. The proposed regulations are necessary to cover the details of all possible circumstances surrounding this requirement and to implement the public policy purpose of this statute. The proposed regulations are consistent with California case law.

The proposed regulations are necessary to ensure that insurers do not attempt to use statements made in an individual's health insurance application in a later rescission, cancellation or limitation of the policy if the application was not returned to the individual at the same time as the policy was delivered. This provision is reasonably necessary in order to further the public

policy purpose behind this requirement and to protect against agent fraud. The Department has received consumer complaints where the insured noticed significant discrepancies in the copy of the application received with the policy in comparison to the information that was provided by the consumer to the agent who in turn submitted an electronic application on the consumer's behalf. The proposed regulation, which requires the insurer to instruct the applicant to notify the insurer if there are any discrepancies on the copy of the returned application immediately, is necessary to detect possible agent fraud and bring this to the insurer's attention immediately. This proposed regulation helps the insurers in the situation where the insured receives and reviews a copy of the original application and is reminded that some potentially material information was not provided to the insurer prior to their completion of medical underwriting of the application. In this situation, the insured can contact the insurer and provide the omitted information; the insurer will then be able to respond accordingly.

Section 2274.78: POST-CONTRACT ISSUANCE RESCISSION OR CANCELLATION INVESTIGATIONS

The proposed regulations concerning how insurers handle post-contract issuance rescission investigations are needed to ensure that existing laws and regulations governing claims handling are followed in this special situation.

Section 2274.78(a) limits the applicability of the proposed regulations to rescission investigations which are conducted when the insurer has either received a claim or is on notice of a claim incurred. For example, when an insurer is contacted by a health care provider, such as a hospital, that the insured is hospitalized and the hospital calls to verify insurance coverage or obtain authorization for the services provided from the insurer, the insurer is on notice of a claim. If the insurer subsequent to such notice of a claim or receipt of claim commences a rescission investigation, the proposed regulations concerning the rescission investigation apply.

Section 2274.78(b) expressly excludes claims investigations that are not aimed at an insurer's decision whether or not to rescind, limit or cancel an insured's policy. Tens of thousands of routine claims investigations are conducted by insurers each month in California; the proposed regulations concerning rescission investigations do not apply to garden variety claims investigations. The proposed regulations provide examples of the types of routine claims investigations excluded from the rescission investigation requirements.

The proposed regulations recognize that insurers are entitled to conduct rescission investigations of insureds' claims submitted or pending under a policy. It is necessary to require that notice of this type of investigation be provided to the insured for several important reasons. First, the insured may be liable for any medical claims generated under the insured's policy that later may not be paid by the insurer if the policy is rescinded. Second, the insured may provide valuable information to the insurer to aid in the insurer's investigation. The insured is not in a position to offer such information if the insured is unaware that an investigation is underway. The insured's

rights to coverage under the insurance policy may be in jeopardy during an investigation and the insured should be informed of this possibility and participate in the investigation, if necessary.

It is necessary to set reasonable limits on the time periods of such rescission investigations since the possible loss of health insurance coverage by the insured would likely cause extreme hardship for the insured, especially if the insured is undergoing a course of medical treatment over a period of time. The proposed regulations require the insurer to take timely action to initiate a rescission investigation if the insurer suspects that a material misrepresentation or omission may have occurred and to document the dates of key steps in the investigation in the claims file. Once on notice, the proposed regulations require the insurer to commence the rescission investigation within 15 calendar days. This proposed timeframe gives the insurer sufficient time to begin the process of requesting documents, such as medical records, to assist the insurer in making a determination regarding a possible rescission.

Section 2274.78(c) sets the standard for an insurer's evaluation of a suspected material misrepresentation or omission; namely, that the applicant must have known the facts sought and have appreciated the significance of the information requested. The insurer is not permitted simply to compare the doctor's notes in a medical record to the information supplied by an applicant on the application. The proposed regulations require further inquiry of the applicant to ensure that the applicant had knowledge of the information omitted or misrepresented on the application. The insurer must determine that the applicant appreciated the significance of the information requested by the insurer. This standard cannot be applied by an insurer without contacting the insured during the investigation.

The proposed regulations require that certain documents relevant to the insurer's rescission investigation be provided to the insured and that the insured be notified within seven days after the insurer commences a rescission investigation. These requirements are necessary to improve communication between the insurer and the insured during the investigation in an effort to expedite the insurer's determination by allowing the insured an opportunity to provide an explanation, insights or new information to the insurer. If the insured is not made aware of the investigation, the insured cannot be involved in a possible resolution of the discrepancy identified by the insurer which triggered the investigation.

The proposed regulation defines the content requirements for the notice to the insured that the rescission investigation has commenced. The insurer is required to clearly explain why the investigation has commenced and to provide documents related to the investigation. The proposed regulations include examples of the types of documents that would accompany a typical notice of rescission. The proposed regulation does not require the insurer to provide documents that are otherwise protected by law. Medical claims submitted by the insured's health care provider on behalf of the insured and the insured's medical records, if used by the insurer as part of the rescission investigation, are required to be provided to the insured whose coverage is under investigation.

The proposed regulations limit the information sought by the insurer during a rescission investigation to what the insurer actually needs to make a timely and proper determination. A rescission investigation is not intended to be a wide ranging fishing expedition but rather a targeted review of relevant information that will aid the insurer in understanding whether material information that the applicant knew at the time of the application, and appreciated was significant to the insurer, was withheld or misstated by the applicant.

The proposed regulation provides a reasonable timeframe for completion of the rescission investigation. The Commissioner has chosen 90 calendar days as a goal for an insurer to conclude a rescission investigation. The proposed regulation allows for a longer timeframe if the insurer can demonstrate good cause. The Commissioner chose 90 calendar days to strike a fair balance between the needs of the insured to know whether or not their health insurance coverage will be rescinded against the needs of the insurer to have sufficient time during which to conduct a competent and responsible investigation. The choice of 90 days recognizes that in most circumstances the insurer's best interest is a quick conclusion of the investigation since the insurer is responsible for payment of claims for authorized care even if a rescission is executed. Existing law requires insurers to pay providers when the insurer has authorized medical care that is covered by the policy at the time the authorization is received. The proposed regulation requires the insurer to notify the insured every 30 calendar days of the status of the investigation and to provide any new information uncovered during the investigation. The Commissioner chose 30 day intervals for notification to the insured in recognition that the potential loss of health insurance coverage is a difficult situation for an insured. In addition, 30 days is sufficient time for an insurer to have received new information in the course of the investigation. The proposed regulation requires the insurer to obtain certain information, such as medical records, directly if needed.

Once an insurer has determined that it is legally allowed to rescind the insured's contract under these proposed regulations and existing law, the proposed regulations require the insurer to notify the insured no later than seven days from the close of the rescission investigation. The insured is entitled to timely notice and receipt of the insurer's detailed findings pertaining to the rescission.

The proposed regulations require the notice of rescission sent to the insured to include notice of the insured's right to ask the Department of Insurance to review the rescission and requires the insurer to provide contact information for the Department of Insurance in the notice of rescission.

The proposed regulations state explicitly the fact that existing law governing claims payment and claims handling is not suspended during the time period of the insurer's rescission investigation. This proposed regulation is reasonably necessary since the Commissioner discovered during market conduct examinations that insurers would simply freeze claims payments and all claims processes, including denial notices with the required explanation of the reason for denying the

claims, while a rescission investigation was underway. By freezing all claims activity during a rescission investigation, providers who have submitted the claims are left in the dark as to the status of the submitted claims. While it may seem self-evident that claims handling laws must be followed even during a rescission investigation, findings in the Department's market conduct examinations pointed out the need for this reinforcement. This proposed regulation covers not only claims handling laws but also laws pertaining to coverage determinations and benefits or eligibility information.

Section 2274.79: SEVERABILITY

The proposed regulation concerning severability is necessary in the event that one or more provision of the regulations or one of the statutes used as reference for these regulations is changed, amended or invalidated by a court. The entire subject matter of rescission and the laws affecting rescissions is in a fluid state at this time. There are many class action lawsuits and other lawsuits pending as well as many legislative proposals dealing with some aspect of the rescission of health insurance. As a result, it is reasonably necessary to anticipate the possibility, even if remote, that a provision of the proposed regulations could be invalidated. The entire set of regulations should not be voided if only one part is invalidated.

IDENTIFICATION OF STUDIES

The Commissioner is relying on the Department's reports of recent Market Conduct Examinations of Anthem Blue Cross Life and Health Insurance Company and Blue Shield Life and Health Insurance Company in finding a need for more detailed and prescriptive standards regarding the subject matter of the proposed regulations. In the aforementioned market conduct examinations, insurer and agent practices including rescission, cancellation or limitation of individual health insurance policies, pre-issuance medical underwriting of individual health insurance applications, related claims handling practices, investigations concerning these actions and the use of proprietary medical underwriting guidelines prior to and after the issuance of such policies were scrutinized in great detail.

As a result of these examinations, the Commissioner identified the necessity for clarification of the statutes governing medical underwriting requirements and rescission standards in the individual health insurance market. The Department's examiners discovered considerable discrepancies in pre-issuance medical underwriting practices between the Department's application of relevant Insurance Code and regulatory requirements and the actual practices of the state's largest health insurance companies. The Department's Examinations also found wide variation in how post-issuance rescission investigations were conducted and how claims affected by these investigations were settled.

The Commissioner has determined that the report, Failing Grades: State Consumer Protections in the Individual Health Insurance Market, issued by Families USA in June 2008 made key findings

of weaknesses in this market which applied to California. The proposed regulations will, only to the extent allowed by state statute, address some of the problems identified in this report. In a June 2008 Health Policy Memo issued in conjunction with the Report, Families USA concluded: *"Consumers expect that when they receive insurance coverage, the insurer has completed the medical underwriting process, and they will be covered according to the terms of their insurance contracts. Unfortunately, most states allow (tacitly, if not explicitly) insurance companies to perform medical underwriting, or to conduct more stringent underwriting, long after a policy has been issued to a consumer.*

SPECIFIC TECHNOLOGIES OR EQUIPMENT

Adoption of these regulations would not mandate the use of specific technologies or equipment.

ALTERNATIVES

The Commissioner has determined that no reasonable alternative exists to carry out the purpose for which the regulations are proposed. Performance standards were considered but were rejected as an unreasonable and impracticable alternative in the context of regulations that seek efficiently to define specific rules for the protection of insureds whose health insurance policies may be subject to rescission, cancellation or limitation and where the prohibition of postclaims underwriting may apply.

ECONOMIC IMPACT ON SMALL BUSINESS

The Commissioner has identified no reasonable alternatives to the presently proposed regulations, nor have any such alternatives otherwise been identified and brought to the attention of the Department, that would lessen any impact on small business. Although performance standards were considered as an alternative, they were rejected, in part, because the kind of risks from which the regulations seek to protect consumers cannot practicably be gauged by means of a performance standard.

PRENOTICE DISCUSSIONS

The Commissioner has not conducted public prenotice discussions pursuant to Government Code section 11346.45, because the many of the affected parties — health insurers who sell individual health insurance policies — who would have been invited to participate in such discussions have been the subject of targeted rescission market conduct examinations where the Commissioner's staff conducted in depth reviews of the insurer's policies, practices, procedures, documents, claims files, underwriting files and other business processes related to postclaims underwriting and rescissions. During the course of these examinations, many discussions between the Department's examination staff and the insurers ensued covering all of the subjects addressed by the proposed regulations. As a result of the market conduct examinations covering the subject matter of the proposed regulations, the affected parties have shared their information, practices,

opinions and viewpoints on the subject matter of the proposed regulations. Companies representing more than 85% of the individual health insurance business in California have been examined by the Commissioner since late 2006. As a result of these discussions and others, even though the proposed regulations are fairly complex, many of the insurers who are the parties affected by the proposed regulations have had extensive contact with Department staff regarding the matters contained in the proposed regulations.